Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Avert Payer Denials for New Psych Codes With These Pointers

Researching the new rules is the key.

If coping with learning the new codes for psychotherapy has kept you on your toes, payer denials for these new codes citing many reasons (some genuine and some frivolous) might have added to your woes focus on keeping the coding right so that you will receive the right reimbursement and avoid the vicious circle of denials.

Review the New Code Groups

This year you've got new code sets for these areas:

Psychodiagnostic evaluations (90791, Psychiatric diagnostic evaluation and 90792, Psychiatric diagnostic evaluation with medical services),

Interactive complexity (+90785, Interactive complexity [List separately in addition to the code for primary procedure]),

Psychotherapy (90832, Psychotherapy, 30 minutes with patient and/or family member-+90838, Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service [List separately in addition to the code for primary procedure]), and

Psychotherapy for crisis (90839, Psychotherapy for crisis; first 60 minutes and +90840, Psychotherapy for crisis; each additional 30 minutes [List separately in addition to code for primary service])

Out with the old: These codes eliminate the previously used codes (90801, 90802, 90804-90809, 90810-90815, 90816-90822, and 90823-90829) for these services.

New codes, new problems: "Some psychotherapy providers have had claim denials since Jan. 1, 2013, when the new CPT® codes were launched," says **David Swann, MA, LCAS, CCS, LPC, NCC**, Senior Healthcare Integration Consultant at MTM Services in Holly Springs, NC. "Frequent reasons for psychotherapy denials include using old code rather than new code, using a code that is not in the payer's benefit plan, or making errors in time-based codes."

You might have faced problems even if you are using the codes right. "The new psychotherapy codes are posing a myriad of complications on the reimbursement side," says **Dreama Sloan-Kelly, MD, CCS**, President of Kelly, Sloan and Associates, LLC whose offices are in Shirley, MA and Dallas, TX. "Many payers were not prepared for the change in the psychiatry section, even though they knew about the codes before they were released. Many payer computer systems were not updated with the code sets and fee schedules until after the start of the New Year."

Stand firm: You might have to put up with some payers asking you to continue using old code sets until they get their systems updated. "There have been many groups that have been told by payers to use the old codes until the system has been updated; however, this is against HIPAA regulations," reminds Sloan-Kelly. "Ideally, the appropriate CPT® codes from the start of 2013 should only be used."

Understand the RVU Related Issues

When CMS introduced RVUs for the new codes, their idea was to keep reimbursement on par with the payments for the old code sets.

"The goal of CMS was to keep the reimbursement rates similar to the old codes, but the changes were so drastic, you are

finding that there are many codes that are often not included on payer fee schedules," says Sloan-Kelly. "CMS has not released permanent RVU's for these codes -- the RVU's associated with this code set are interim and probably will not be set in stone until 2014."

"There are also some apparent anomalies in the 2013 RVUs," says **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians. "For instance, code 90791 has more total RVUs than 90792, even though the latter code also includes medical services."

Set a Pattern of Accurately Applying New Codes

Be patient and persistent where pay for new psych codes is concerned. "Many times, these issues work themselves out after the first quarter when most payer systems have been updated and are ready to receive the correct codes," adds Sloan-Kelly.

Key: Learn the right usage of the codes that have been introduced and avoid using the old code sets. When you bill correctly, you have a leg to stand on. "If you change back to the old codes and try to appeal (especially if you have no proof of someone telling you to bill that way), you may have no recourse in being reimbursed properly," says Sloan-Kelly.

For instance, if your psychiatrist performed an interactive psychiatric diagnostic interview examination without any additional medical services in 2012, you would have reported code 90802 (Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication). In 2013, the same service requires you to report two codes: 90791 (Psychiatric diagnostic evaluation) and +90785 (Interactive complexity [List separately in addition to the code for primary procedure]).

In another example, individual outpatient psychotherapy of 30 minutes with medical evaluation and management (E/M) services in 2012 required you to report 90805 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services). In 2013, you'll report the same service with two codes: an outpatient E/M code (99201-99215) plus +90833 (Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service [List separately in addition to the code for primary procedure]).

"If you get a denial, look for the reason for the denial and research the rules to make sure that you indeed billed for the service correctly," adds Sloan-Kelly. For instance, it has been reported that some Medicare carries are denying the new psychotherapy codes based on place of service, even though the new codes, unlike the old codes, are not specific to a particular site of service. Other payers are reportedly denying payment for the new codes simply because they do not yet have them loaded into their claims processing system.

Tip: You can even try to see how different payers are paying for these psychiatry codes and create a comparison. You can create a spreadsheet of how you are being reimbursed for the psychotherapy and other psychiatric services codes and check to see if there is any variation among payers. This will enable you to get a better idea about understanding if payers are providing the right reimbursements for these codes.